STRATEGY RESEARCH PROJECT

TRANSFORMING ARMY MEDICINE: DISCOVERING RELEVANCY THROUGH REFORMATION

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USAWC STRATEGY RESEARCH PAPER

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ABSTRACT

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The fierce competition for limited dollars demands that every operating agency and every program be challenged for relevancy and cost-effectiveness throughout the defense establishment. In an effort to improve and bolster the relevancy of the Army Medical Department (AMEDD), this paper proposes four areas for change. First, it recommends eliminating military graduate medical education, contracting this training with private institutions, and reinvesting the savings in direct health care. Second, this paper supports the adoption of user fees to contain AMEDD health care costs and thereby avoid a fiscal collision with national priorities such as MEDICARE, MEDICAID, and Social Security. Third, it advocates a revolution in the preparation of AMEDD doctrinal literature. This process must evolve into a virtual collaborative endeavor, and restructure itself to leverage expertise everywhere, everyday, within the AMEDD. Fourth, this paper advocates financial assistance to young aspiring Reserve Component providers who are just starting their practices after completing their training. This proposal also advocates awarding retirement credits to all Reserve Component medical providers in exchange for preferential fee schedules for the treatment of beneficiaries.

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TRANSFORMING ARMY MEDICINE: DISCOVERING RELEVANCY THROUGH REFORMATION

Technological advances, globalization, demographics, and an emerging rage among the economically disenfranchised of the world are major changes that herald the 21st Century National Security environment.[1] The Army Medical Department (AMEDD) must change to ensure its relevancy to the Army and the national security environment. Unless change is anticipated and managed, it will relentlessly descend upon the AMEDD. To successfully manage this change, the AMEDD must set aside any parochial biases and avoid clinging to its status quo. The AMEDD must retain force structure and programs by virtue of necessity rather than tradition[2]

There are many unnecessary claimants for resources within the Department of Defense (DOD)[3]. These claims needlessly accelerate a fierce competition for limited resources across DOD and the Army. The continued division of a resource base experiencing little or no real growth results in marginal, if not insufficient, resources to its claimants. The AMEDD is no exception to this truism.

The initial allocation of resources throughout the AMEDD is barely sufficient to cover costs. This is attributable to reduced defense budgets, increased demand for health services, pared numbers of health facilities, and the post Cold-War drawdown[4]. These marginal resources force leaders to address near term missions that are highly visible—peacetime health care—at the expense of wartime readiness.[5] These trade-offs occur, in part, because health programs blanch in priority against other essential programs that include general-purpose forces, force modernization, and weapon systems procurement.

The fighting and winning of the nation's wars is the Army's mission by law[6]. This mission is inherently a dangerous profession. America's Army is a national treasure—it is young men and women dedicated to preserving the nation's freedom even if this means paying the ultimate price. The Army is morally obligated and, by necessity, required to provide the best possible equipment and support services for its soldiers. The provision of health services by the AMEDD is a critical component of these essential support services.

The use of the term relevancy in this paper strives to bring together the qualities of efficiency, innovation, and competitiveness into a one- word description of a desired end-state for the AMEDD. Competitiveness specifically refers to the capability to compete against other Army and DOD entities for the allocation of scarce human and financial resources; efficiency and innovation hone the competitive edge of an organization.

This paper will first provide a description of the environments that are driving forces for programmatic and organizational changes within the Army and the AMEDD. Then, four proposals will be examined that can potentially enhance the AMEDD's relevancy and improve its utilization of medical resources. The ideas are the

- elimination of military graduate medical education within AMEDD facilities
- adoption of user fees for military health care beneficiaries
- transformation of the Army doctrinal development process within the medical community
- the compensation of Reserve Component (RC) health care providers with retirement point credit for health services provided through their civilian practices.

TODAY'S ENVIRONMENT—POLITICAL, ECONOMIC, AND MILITARY CONTEXTS

The following discussion provides background concerning the political, economic, and military environments affecting both national security and the AMEDD today. This discussion will facilitate an understanding of why innovation and efficiency must be sought—and not imposed. Before turning to a discussion of the environment, some explanation of the AMEDD's relationship to the DOD hierarchy is necessary.

First, the AMEDD receives its funding for peacetime health care from the DOD in the Office of the Assistant Secretary of Defense, Health Affairs. Second, the AMEDD requires congressional authorization to implement any recommendations of this paper pertaining to the adoption of user fees or the integration of the RC medical providers into the TRICARE network. The DOD must join, if not lead, the AMEDD in the advocacy of these proposals to Congress. Third, some if not all of these proposals, will affect the sister services' medical departments. The uniqueness of service culture and their associated traditions presents an opportunity for politics to unnecessarily thwart the implementation of these ideas.

This paper proposes that the AMEDD exercise leadership and innovation, serve as the standard-bearer for excellence, and assume its rightful place in front of the sister services on the highway of innovation. Therefore, this paper will place the burden of leadership upon the AMEDD to implement changes, and in doing so, will place emphasis upon the AMEDD's role and responsibility in advocating change. The approval of Congress, DOD, and possibly the consensus of sister service medical departments will decide the adoption or rejection of these ideas. Every cause requires an advocate—the AMEDD has been appointed the advocate in this paper.

POLITICAL CONTEXT

To fully understand the pressures facing the AMEDD, one must grasp the mood and sentiment of the American public. The civilian health care industry faces intense economic and commercial pressures to contain costs while maintaining high standards of health care. The civilian health care industry has implemented managed care plans within the last ten years in an effort to achieve the precarious balance of quality health care and cost containment. Managed care, although controversial, is an accepted way of accessing health care today[7].

The plight of the uninsured and the rising cost of health care are political issues. The Clinton Administration proposed health care reform legislation in its first term; Congress and the American public soundly rejected that proposal. This period of legislative debate heightened public awareness and spurred consumer interest in the details of health care policy.

It is no surprise legislators and their constituencies are somewhat lukewarm to complaints by DOD health care beneficiaries regarding any inconveniences associated with TRICARE. Similarly, they are not particularly alarmed by the inability of the AMEDD to independently serve its beneficiary population utilizing its own military health care system. Until the American public decisively resolves its health care policy and associated standards of care, AMEDD beneficiaries should expect little empathy concerning inconveniences of the military health care system including its extension, TRICARE. The issues of health care access, entitlements, and standards continue to perplex the American public.

One cannot discount the recent passage of the "TRICARE for Life" legislation. This act appears to contradict the above observations. Although this legislation indicated strong political interest in military benefits, it did not commit or appropriate additional resources. It merely added one more claimant to compete for resources that experienced no growth. This legislation, until it is vindicated by the passage of time, remains an illusive, temporary, and rhetorical expression of interest in the military by the Congress. The national agenda and the public interest are currently focused outside of military affairs and national security matters.

Both the private sector and AMEDD beneficiaries are monitoring the stewardship of tax dollars—especially defense programs and national entitlements such as MEDICARE, MEDICAID, and Social Security. An AMEDD failure in stewardship risks its relevancy, imperils its competitiveness for Army force structure, and erodes its credibility in competing for DOD health care dollars. Such failure places the entire DOD peacetime health care system at risk and

strongly suggests the alternative of contracting for the peacetime health care services. The successor health care system may be even less appealing to DOD beneficiaries. The consequences upon the wartime mission could be significant, if not crippling. Such change is not inconceivable; recent studies are questioning the legitimacy and cost effectiveness of military functions or structures that compete with other national security issues or other popular national priorities that revolve around entitlements.[8]

ECONOMIC CONTEXT

The defense budget's declining share of the larger national budget exerts strong pressures on both the Army and the AMEDD to achieve the greatest possible return on an expenditure of the tax dollar. The defense budget has declined in response to the changing geo-strategic landscape and the changing priorities of the American public. This proverbial tax dollar provides the means for military procurement, force structure, and the retention of people. Unfortunately, there are not enough dollars to fully support all programs.

Fiscal Year (FY) 2001 estimates project that 65 percent of the tax dollar will pay for mandatory national entitlements. These mandatory entitlements comprise cherished programs such as Social Security, MEDICARE, and MEDICAID.[9] Discretionary spending will account for the remaining 35 percent of that tax dollar. Within this 35 percent of discretionary spending, 16 percent will pay for national defense expenditures. The Defense Health Program (DHP) represents 6.1 percent of the total defense program in FY 2000; this program funds the peacetime health care mission for the three services.[10] The AMEDD competes at DOD for its share of DHP dollars, and within the Army for force structure. DHP shortfalls can thrust the AMEDD into an even stiffer competition for dollars with the Army.

The defense budget's declining share of the larger national budget and the recent strength of the economy exert strong pressures on the AMEDD to optimally calibrate its fiscal resources, force structure, and human resources to achieve maximum productivity—in support of both peacetime and military contingency operations.

MILITARY CONTEXT

The revision of the National Security Strategy, National Military Strategy, and the downsizing of the Army during the 1990s had a profound effect upon the Army and the AMEDD. The excess AMEDD capacity of the Cold War, based upon providing support to a heavy force

that anticipated high casualty rates, had provided the resource base for providing health care to beneficiaries.[11] Times have changed. Downsizing, base closures, and the retiree population have changed this resource base. In 1999, the Army announced it would undertake a transformation to improve its response to future national security challenges.[12] This transformation began amid tight and declining defense budgets and the Army looked internally to finance much of its transformation in its early stages.

Today, the AMEDD is divided in its priorities, providing peacetime health care services to authorized beneficiaries while endeavoring to provide combat health services (CHS) in various operational environments around the world. Unfortunately, it employs much of the same force structure to achieve both missions. An assertive retiree beneficiary population and a smaller military stress the process of prudently allocating scarce medical resources. The institutional AMEDD executes the peacetime health care mission. The institutional AMEDD is often referred to as the Table of Distribution and Allowances, or TDA, AMEDD. If it were not for TRICARE, a chain of managed care networks or similar supplemental health care system or plan, then the AMEDD would be unable to provide peacetime care to its authorized beneficiaries.

The peacetime health care mission is financed by funds from DOD referred to as the DHP. The AMEDD, through the U.S. Army Medical Command distributes these funds to its subordinate medical activities. Often the DHP has insufficient funds to cover costs for any given year. In response, the DOD must distribute additional funds if available. In the event no additional funds are available, then the services--the Army in the case of the AMEDD--must make up the difference. Or in another scenario, costs for the DHP may exceed the top-line programmed by DOD. In that case, DOD again levies the bill to the Army.[13] The Army then must find a bill payer to meet the DHP obligation. This diminishes the resources available to the Army and thus indirectly affects the AMEDD. The AMEDD is then limited in its ability to execute other programs such as the reengineering of its deployable forces.

The AMEDD operational Corps and Echelon Above Corps (EAC) force structure that supports deployed forces has been downsized in the last ten years. This force structure was lacking mobility and organizational flexibility during Operation Desert Shield/Desert Storm. The AMEDD reengineered these elements—striving for less weight and volume—without compromising medical capability. The resultant organizations require less transportation and logistical support.[14] This reorganization is known as the Medical Reengineering Implementation (MRI)[15]. Some of the MRI organizations have already been fielded. The MRI hospitals are programmed for fielding beginning in FY 03[16].

When completed, this fielding will result in an operational force more responsive to the National Military Strategy and, fortuitously emerge as a credible prototype for supporting a transformed Army. A standardized and modular design is among the more significant improvements in the MRI. This modularity is conducive to split-based operations, deployability, mobility, and tailoring for specific missions.

The funding for new organization and doctrine training teams will compete for critical resources at the time the Army begins to field the initial combat brigade team (IBCT) and the interim force.[17] These training teams are critical to successful fielding of MRI organizations. This training will minimize the impact of the MRI reorganization upon unit readiness. Unfortunately, resources remain constrained and insufficient to support current Army programs. The affordability and sustainability of Army Transformation and MRI will present Army leaders with difficult decisions. The risk associated with these decisions can only be ameliorated through an increase in available resources. Such an increase in resources can be realized by achieving efficiencies across the AMEDD, and possibly, through an increase in the DHP.

The AMEDD will face a daunting, but not impossible job, of competing for the necessary funds during what promises to be the most competitive of times within the Army and the DOD resource arenas. The following proposals are not all inclusive of measures capable of honing the competitive edge of the AMEDD. These four ideas are supportive of the AMEDD mission vision statement that says the AMEDD strives to become "The integrated and responsive system of choice for quality health services in support of America's Army at home and abroad, accessible to the Army family, accountable to the American people."[18]

AMEDD PROGRAMS AND POLICIES—RELEVANCY AND COST EFFECTIVENESS

GRADUATE MEDICAL EDUCATION (GME)

Over the years, the cost, size, scope, and location of GME have been topics of discussion among politicians and analysts.[19] The AMEDD GME matriculates aspiring Army physicians through ten different programs throughout CONUS.[20] In 1997, the Army had 1297 GME trainees. The estimated cost of GME ranges from $20,000 to $100,000 per student.[21]

These training programs span the continuum from obstetrics-gynecology specialists to emergency room medicine specialists. The AMEDD depends upon GME to provide the appropriate mix of provider skills for wartime and peacetime missions. The AMEDD views GME as essential to physician recruitment and retention programs.[22]

Discussions concerning GME inevitably digress to the topic of military physician readiness and the relevancy of the program to such readiness. One major concern is physician readiness to manage large numbers and types of trauma patients in a relatively short time. Critics of military GME argue that the types of patients seen in many military medical treatment facilities are not trauma patients.[23] They are frequently non-emergent patients that often represent illnesses and injuries atypical of those expected in a military operation. The GME residents in training will see neither the variety nor desired density of trauma patients unless the military medical treatment facility is designated as a trauma center for the city. Wilford Hall Air Force Medical Center and Brooke Army Medical Center in San Antonio, Texas are examples of such trauma centers that are also GME institutions.[24]

Discussions about the efficiency and cost-effectiveness of GME ultimately reduce to analysis of the costs of teaching staffs, the costs of training GME students, and the contribution of both students and staffs in accomplishing the direct health care workload. The costs of teaching staffs and other costs of training GME students represent part if not the majority of the overhead of executing a GME program. As of 1997, these overhead costs could not be determined precisely because of inadequate, non-standardized accounting procedures among all the military service medical departments.[25]

Advocates of military GME assert that some of the GME staff and students are involved in direct health care and are therefore contribute to the provision of direct health care.[26] They assert that the military GME programs do not significantly decrement the provision of direct health care. Some advocate that GME should either be reduced in size or contracted with civilian institutions that have similar GME programs. They suggest that the overhead of military GME programs should be invested in providing direct health care to authorized beneficiaries within DOD or supporting core missions such as full-time manning of operational medical units and staffs.[27] This would improve productivity within a medical treatment facility and reduce the numbers of patients forced to more expensive civilian sources of health care.

The most lucrative and visible benefit for the taxpayer would be reducing the size of GME without reinvesting these resources in the AMEDD, the Army or DOD. GME's contribution to physician accession and retention and its perceived contribution to direct health care all argue against the wholesale elimination of structure and dollars associated with GME programs. The insatiable demand by the peacetime health care system for dollars argues strongly for reinvesting GME savings into direct health care.

The AMEDD and the beneficiary population both benefit from any reinvestment from GME. Reinvestment of resources into direct health care reduces the dependence upon civilian

providers within TRICARE. Reinvestment in direct health care reduces DHP bills. The Army benefits from such savings through either avoidance or reduction of unforeseen DHP bills from DOD. Army budget analysts pay DHP bills to DOD at the expense of an Army program—e.g., training, force modernization, and quality of life programs.[28] AMEDD programs, such as procurement programs and war reserve stock programs, are also vulnerable to these DHP bills, because the Army and not DOD fund such programs. These programs already lack sufficient funding and cannot afford further reductions in either the budget years or program years.[29]

Lack of definitive GME accounting systems and the weak administration of TRICARE contracts muddle the debate over GME. The GAO reports and other reviews point towards contracting these functions with private institutions. As mentioned earlier, GME advocates fear an adverse impact upon the direct health care mission if the AMEDD contracts GME with private institutions. The reinvestment of savings from GME into direct health care would mitigate any such risk in capability. Therefore, the AMEDD must move GME programs to civilian institutions and reinvest the savings into the direct health care mission. A sound transition plan, accompanied by meticulously drafted contracts, will provide more resources for direct health care and divest the Army of overhead that can be utilized in the larger Army Transformation. Because of the aforementioned imprecise nature of accounting systems, the potential savings are difficult to derive, but a 1995 DOD Inspector General study estimated that the DOD GME program cost $125.6 million for 15 medical centers throughout DOD.[30] The impreciseness of the estimate and the accounting system indicate that this may be a conservative estimate of the costs. Nevertheless, the potential savings are significant whether viewed from a service perspective or as a total savings across DOD.

USER FEES

The AMEDD must adopt co-payments for care for all categories of beneficiaries. This will eventually generate additional revenues to offset costs within the AMEDD. In 1984, modest user fees of $5 and $10 had projected revenues of $500 million and $845 million, respectively. The associated administrative costs of $90 million and $120 million had been attributed to the $500 million and $845 million proposals, respectively. These estimates also included active duty soldiers paying user fees.[31]

User fees will restrain those beneficiaries who visit the military health care system even though they really require no medical treatment. These beneficiaries inflict an opportunity cost upon other beneficiaries who visit the health care system out of medical necessity. The

opportunity costs are manifested as lengthy waiting times for appointments or lengthy waiting times to see a health care provider during a scheduled appointment.

Any serious consideration of user fees must include a grandfather clause for all current retirees, active duty members, and reservists serving at the time of its implementation. The savings from these fees will grow over time as the grandfather-force retires or otherwise exits the military. A user fee will not be politically palatable in the near term, especially among retirees and those with extensive time invested in service with the understanding that their health care would be free of charge. However, such user fees will eventually reduce the number of unnecessary visits to military medical facilities. This will also reduce waiting times for those who have legitimate medical needs but who are trapped in queues behind those with disputable medical needs.

The probability of success for such a fiscal reformation is doubtful at this time due to the recent legislation passed by Congress—known as "TRICARE for Life". For the short term, this poses a formidable political obstacle for imposing any user fee. For many beneficiaries, this legislation affirms the expectation of free health care for life. Congress failed to concurrently appropriate funding for the "TRICARE for Life" authorization in fiscal year 2001.[32] A supplemental appropriation is being sought to cover these costs. Its long-term affordability is questionable, especially when considered in view of other national entitlements.

Patience and tenacity in pursuing a user fee offers a revenue source to mitigate long-term health care costs within the military. The beneficiary population is about to crest in size; it comprises a miniscule number of World War I veterans, a declining World War II veteran population, many Cold War veterans, and a smaller post Cold War population. With the drawdown of the military in the 1990s, the eligible beneficiary population will decline over time even further, especially within the ranks of the retiree population.

The implementation of user fees with new accessions would begin a new chapter in the history of the AMEDD and the military. This cohort would mitigate the cost of their own health care through user fees. They would also enjoy better access to care through a reduction in unnecessary visits to the health care system by those with disputable medical needs. These user fees must ensure affordability across all of ranks of the beneficiary population. Yet these fees must be substantive enough to discourage unnecessary access to the military health system. The appropriate index will keep fees below private sector health care co-payments or user fees. This will uphold the military health care system as an enticing and substantive benefit of Army service. Finally, user fees must cover associated administrative costs that arise as a

result of implementation. Information technology should increase revenues by reducing restrictive administrative costs that were estimated in the above 1984 study.

As mentioned earlier, the fiscal sustainability of existing national entitlements, the impact of any tax reforms on tax revenues, and other national priorities advocated by various lobbyists and study groups favor the adoption of user fees. Such fees ensure not only the viability of the defense health care system but also contribute indirectly to the continued solvency of Social Security, MEDICARE, and MEDICAID.

The authorization of TRICARE for Life and other health related Quality of Life enhancements are generous gestures offered to DOD by Congress. Central to the 2000 Presidential Campaign were long-term concerns about the solvency of Social Security, the solvency and efficacy of MEDICARE, and other entitlement programs. The long term prospects for free health care for DOD beneficiaries appear slim if trends continue towards reduced national spending, constricted defense budgets, and a growing expectation that entitlement programs such as Social Security should be more self-sufficient. These trends could later force legislators to abandon promises implied in politically popular but fiscally irresponsible legislation such as "TRICARE for Life".

If Social Security evolves to an arrangement partially subsidized by the private investments of the citizenry, then the AMEDD should see this as the bow wave for additional fiscal reforms in other entitlement programs. If the AMEDD (and DOD) exercise boldness and advocate the adoption of user fees in new accessions, then the AMEDD will accomplish two critical tasks. It will implement a long term, but fiscally sound plan to partially subsidize the AMEDD peacetime health care system. In the near term, it will protect against any politically expedient attempt to defray military health costs by breaking perceived contracts with current beneficiaries concerning their free health care. The passage of time will not make this any more appealing for future generations of AMEDD beneficiaries. Any policy change in the future may take something that had ostensibly been promised—free health care. The suggested approach of a grandfather provision and implementing user fees with new accessions takes nothing from any group. The health services benefit is defined, and clearly understood upon accession into the Army.

The adoption of user fees enhances the cost-effectiveness of AMEDD health care and ensures its affordability in the future. At some point in time, the military health care system must partially pay for itself. Programs, such as Social Security and MEDICARE, that partially generate their own revenues, will enjoy support from taxpayers ahead of a military health care system that does not generate any revenue in support of its own operations.

DIGITAL COLLABORATION

A virtual, collaborative, community of practice would enhance the development of doctrine and related matters during turbulent times such as the Army Transformation and assist in maintaining the relevancy of doctrinal publications. The current system indulges high costs and limited relevance over time.

The Army Training, Doctrine, and Literature Program has evolved over the years and become more responsive to the needs of the field through advances in information management. Its costs include salaries for Department of the Army civilians, printing costs associated with multiple developmental drafts, and postage associated with staffing these various drafts throughout the Army. The publication timeline for a document ranges from 18 to 24 months. Strong command emphasis and interest in a particular product compresses this milestone to 6 to12 months—that results in a final draft and limited distribution throughout the Army. In the past, it was not unexpected that a change in a combat development domain such as training, doctrine, leader development, organizations, or materiel might change significantly while a corresponding doctrinal draft circulated for comment and coordination throughout the Army. This change would protract the entire publication timeline and magnify any existing doctrinal inconsistencies. Revisions, essential to addressing any changes in the combat development domains, inordinately delay the publication timeline under the current system.

The AMEDD possesses the steel and concrete of a digital enterprise in the form computers, local area networks, intranets, extranets, and the internet. In some cases, it possesses the requisite software to execute digital collaboration.[33] With minimum investment, the AMEDD can collaboratively define, write, coordinate, approve, and distribute doctrine in a virtual manner. Establishing both centers of excellence and virtual communities of practice are commonly accepted and advocated within organizations today.[34] A virtual, collaborative environment reduces or eliminates technical writer positions and their associated costs of salaries and retirement plans. It provides near real-time doctrine to accompany AMEDD changes in doctrine, training, leader development, organizations, materiel, and soldier support systems. It provides transparency in the status of AMEDD doctrine and training publications and facilitates timely contributions by knowledgeable people who are remote to the schoolhouse but familiar with a doctrinal issue under consideration. A virtual community of practice offers not only manpower savings, but also printing cost reductions, and responsiveness to the changing doctrinal needs of the AMEDD.

This virtual environment requires certain procedural safeguards against the unauthorized modification of doctrine by unqualified parties. Protocols would be required for the review and approval of virtual doctrinal products. A virtual, collaborative environment requires hierarchies divided among thinkers, reviewers, and approval authorities. Ideally, thinkers throughout the Army would debate and discuss a particular doctrinal publication through a chat room, video-teleconference or other web site. Reviewers would evaluate the feasibility of ideas forwarded by thinkers and send these electronically to approval authorities (U.S. Army Medical Department Center and School Commandant or his/her Director of Combat Developments) for inclusion within the AMEDD's "Doctrinal Knowledge Network". These approved doctrinal products would reside in digital libraries at proponent schoolhouses and other designated web sites.

Security procedures could diminish the above advantages. Doctrine, among other combat development topics, is a product of lessons learned and advances in technology. These improvements when manifested in doctrine are potentially sensitive with respect to the national security. The U.S. Army Training and Doctrine Command (TRADOC) is the Army's executive agent for doctrine development and has published guidance on the coordination and staffing of doctrine on the web in TRADOC Regulation (TR) 25-36.[35] This regulation requires doctrine developers to protect their digital doctrinal products with passwords.

Internally, security procedures would be needed to authenticate the permissions of reviewers and approval authorities to make and approve changes within the virtual environment. Security measures must not impede the implementation of this virtual system. The costly and burdensome manual system that is augmented by automation must evolve to a virtual, collaborative community of practice. These changes require more than the status quo—the existence of the Army's Digital Training Library[36], the use of computers to prepare drafts, and the existence of digital doctrinal products at proponent school web sites. It requires either the reallocation of resources or the reduction of resources now committed to the technical writing effort by civilians whose recent military experience is either non-existent or obsolete.

Such change requires energy to ensure that subject matter experts in the field are contributing to the knowledge of the AMEDD by collaborative means. Notebook computers must not only facilitate routine electronic mail communication, but also provide the means for virtual coordination across the AMEDD on current or emerging combat development issues. Procedures for collaboration must be friendly to the field, and not forbidding with regard to format, style of language, etc. Such editing can be done at the proponent schoolhouse by the aforementioned reviewers—or in the future by artificial intelligence.[37] Such virtual collaboration must span the entire AMEDD—throughout the active components, United States Army Reserve,

and National Guard. It must address the entire continuum of health services support. It must involve discussion of ambulance exchange points in the main battle area as well as the issues related to consequence management of incidents caused by weapons of mass destruction.

Doctrinal publication development is a task directly related to information management (IM). The emerging IM fields of knowledge management and artificial intelligence both offer the promise of savings. Many tasks which incur costs such as salaries, pensions, printing, and postage can be reduced if the AMEDD and the Army change their expectations with regard to the medium for approved doctrine, where that doctrine should reside, and how knowledge related to doctrine is managed.

The current practice of managing doctrinal changes sequentially, with paper, in multiple drafts, is ecologically unsound, technologically backward, and financially unaffordable. Virtual, collaborative communities of practice will enable the transforming Army and AMEDD to doctrinally keep pace with the future in near real time. The savings from such a business practice could then be reinvested into direct health care or medical force modernization.

LEVERAGING THE RESERVE COMPONENTS (RC)

Recent operations, most notably Operations Desert Shield/Desert Storm (DS/DS), involved a significant portion of the medical RC. A significant number of reserve component health care professionals lost otherwise successful practices as a result of their deployments in support of the Gulf War and the various operations in the Balkan region. This has been chronicled[38] and discussed frequently since the war. The former Army Surgeon General, Lieutenant General Ronald Blanck, reported early in the spring of 2000 that 34 percent of Army Reserve physicians who deployed to the Balkans subsequently departed from military service.[39]

As an adjunct to TRICARE or an alternative to TRICARE, the AMEDD must designate medical professionals who serve in the RC as preferred providers within the TRICARE network. This offers a number of advantages. It reduces dependence on civilian providers in TRICARE, increases revenues to RC medical providers' civilian practices, and contributes to their professional satisfaction in both military and civilian medicine. Such intangibles reinforce physician recruiting and retention efforts in the service [40]

Ideally, this expanded RC provider network would be organized in the following manner. Reserve component personnel who join the TRICARE network (or any successor network) would offer reduced fees less than that now reimbursed to TRICARE civilian providers. The RC providers would constitute a cohort of preferred providers within the larger preferred network of

providers in TRICARE. In exchange for a preferential fee schedule to DOD beneficiaries, these RC medical providers would receive retirement point credit that would be indexed to the number of DOD beneficiaries seen within this program. Such accrual of retirement point credit would be based upon a retirement point per designated number of DOD beneficiary visits, or an increment of a retirement point for a single DOD beneficiary visit. This accrual of retirement points would be in addition to whatever the reserve member would accrue under the existing retirement system for RC personnel. Additionally, such an arrangement with its favorable fee schedule could stabilize or reduce costs associated with TRICARE while expanding the TRICARE provider network.

This arrangement also reduces the impact of deployments upon the provider's practice. Unlike non-DOD beneficiaries, the DOD clientele would maintain at least a tenuous connection to the RC provider during deployments by virtue of the provider and patient's common identification with military service and DOD. During the RC provider's deployment, the DOD beneficiary would continue to receive care through either the AMEDD or the existing extension of the AMEDD. Today, that extension is TRICARE. The DOD beneficiary would not permanently abandon the RC provider just because of the provider's military deployment. If the patient is otherwise satisfied with the RC medical provider, then the patient could return to the provider upon his redeployment. Moreover, the RC provider's practice would recover more quickly than before by virtue of the potential revenue afforded by old and new patients–some of which would be DOD beneficiaries—returning to the practice. Depending upon a beneficiary's location and status, DOD health care policy might dictate his or her return to the RC provider.

To further entice health care professionals, the AMEDD would reinforce established practices where RC health care providers rotate in and out of DOD outpatient clinics and operating rooms on drill weekends, reducing both outpatient appointment backlogs and any existing elective surgery backlog. This would recapture some workload otherwise lost to TRICARE civilian providers due to the lack of either facilities or staff and consequently reduce costs. Voluntary participation in such a program in addition to regular drill would also result in the accrual of additional retirement point credits.

There are two additional ideas for improving RC recruiting and retention which round out this discussion. First, the AMEDD should develop a program to pay the tuition bills of physicians who did not attend professional schools under another DOD loan, grant, or scholarship program. Second, the AMEDD should consider paying the malpractice insurance of RC physicians. These two ideas would prove especially attractive to younger RC providers who are endeavoring to establish practices, start families, and repay education bills. It would also infuse the RC

medical community with much needed youth and thereby build the base for growing future leaders. These two ideas came from within the ranks of the RC medical community. This source viewed these two ideas as more attractive, practicable, and supportive of RC medical recruiting and retention efforts than the above idea of leveraging RC civilian practices within the TRICARE system.[41]

One can reduce the costs of direct health care by leveraging the AMEDD RC to recapture lost workload to the civilian providers within the TRICARE network. The AMEDD must explore awarding retirement points to RC medical providers in exchange for examining a certain number of beneficiaries. This may require some changes in the law with respect to the accrual of retirement points and it might evoke the political interest of various medical organizations. Retention and recruiting of RC medical providers would be enhanced by providing financial aid in the form of payments for malpractice insurance and paying education debts. These would not only improve recruiting and retention of RC providers but also galvanize the active and RC into one tightly knit team and truly promote active component and reserve component integration. All of these changes offer the RC provider convergence of a career as a civilian health care provider and a career as a member of the Army health care team. Consequently physician retention and recruiting would be maintained if not significantly improved.

CONCLUSION

The end-state of the Army and AMEDD is elusive at this time due to the lack of funding, changing environments, and political decisions attributable to policy and organizational reviews undertaken by a new Presidential Administration. The larger certainty--that change is imminent--eclipses any uncertainty about how, when, and what change will be implemented. That certainty is underscored by the frenetic pace surrounding the Army Transformation and the profound changes recommended by the National Security Study Group[42].

This paper addressed four opportunities for change that exist within the AMEDD. First, it recommended eliminating military graduate medical education, contracting this training with private institutions, and reinvesting the savings in direct health care. Second, this paper supported the adoption of user fees to contain AMEDD health care costs and thereby avoid a fiscal collision with national priorities such as MEDICARE, MEDICAID, and Social Security. Third, it advocated a revolution in the preparation of AMEDD doctrinal literature. This process must evolve into a virtual collaborative endeavor, and restructure itself to leverage expertise everywhere, everyday, within the AMEDD. Fourth, this paper advocated providing retirement

credits to Reserve Component medical providers in exchange for preferential fee schedules for the treatment of beneficiaries and services. This proposal also included offering financial incentives to the young cohort of RC providers facing the financial challenges of establishing their own practices.

These proposed changes primarily impact the institutional AMEDD, but the operational side of the AMEDD will also face change as the Army transforms in response to the changing national security priorities. The AMEDD MRI is but the first step and not the end unto itself. The 21st Century environment demands the AMEDD look even deeper within itself to seek opportunities for efficiencies and innovations—or else risk its relevancy. The failure to discover and embrace new opportunities will result in the AMEDD choking on the dust of obsolescence and irrelevance.

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